DRN-5277211

The complaint

Mrs G has complained about the way that St. Andrew's Insurance Plc has handled a claim she made on a mortgage payment protection insurance policy and that it has stopped payments.

What happened

Mrs G made a sickness claim on the policy which St. Andrew's started to pay out from 22 November 2023. In January 2024 her medical reason for being unable to work changed. St. Andrew's asked for more information, including access to her medical records. It then stopped paying the claim on 20 March 2024.

Our investigator thought that St. Andrew's had acted reasonably in the way it handled the claim. Mrs G disagrees and so the complaint has been passed to me for a decision.

What I've decided – and why

I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

Mrs G has provided detailed submissions in support of her complaint. As an alternative dispute resolution service, I won't be addressing every single point in the way that she might wish. I intend, instead, to focus on the main matters at hand. However, I would like to assure her that I have read and considered everything that she has provided.

I've carefully considered the obligations placed on St. Andrew's by the Financial Conduct Authority (FCA). Its 'Insurance: Conduct of Business Sourcebook' (ICOBS) includes the requirement for St. Andrew's to handle claims promptly and fairly, and to not unreasonably decline a claim.

St. Andrew's received the completed claim pack on 8 December 2023. The original reason for Mrs G being signed off work was due to surgery she had on 23 November 2023 and then post-surgical recovery. On the claim form, she wrote: '*I DO NOT GIVE PERMISSION FOR YOU TO ACCESS MY MEDICAL RECORDS'.* At this point she anticipated needing another couple of weeks off work.

As the medical certificate provided didn't set out the condition that had necessitated the surgery, it wrote to her asking for further evidence. Mrs G responded by providing a revised fit note. But although it gave slightly more detail about the type of surgery, it again didn't confirm the medical condition. As St. Andrew's needed to know that the surgery had been medically necessary, it again asked for evidence confirming the condition and reason for surgery. Alternatively, it said she could complete the access to medical records form so that the information could be obtained directly from her GP.

Further sick notes dated 22 December 2023 and 2 January 2024 again did not include details of the medical condition. On 15 January 2024, Mrs G did provide a letter from her surgeon. Although this again didn't give any details of a diagnosis, Mrs G's covering email

alluded to what the issue might have been. At that point, St. Andrew's made an initial payment on the claim, based on the information that it did have. It therefore paid the claim for the period 22 November 2023 to 6 December 2023 for post-operative recovery.

Mrs G then provided a fit note dated 18 January 2024 in which the reason for being unfit to work had changed to '*stress related problem'*.

On 26 January 2024 St. Andrew's advised that it was making another payment to cover 7 December 2023 to 20 January 2024. However, in that payment notification it said:

'As your condition changed to a psychological illness from 18th January 2024, we can only consider payments for a maximum of up to 3 months from this date. Following this, further payments cannot be made without evidence that you are under the care of a specialist. This will include a Psychiatrist, a Psychologist or any mental health nursing team other than you own General Practitioner. This should be in the form of a copy of the specialists report to your Doctor following your initial consultation. We may also require ongoing evidence that you remain under the care of an appropriate specialist for the remainder of your claim.'

Mrs G provided evidence that she had self-referred to a talking therapy service and explained that the GP didn't routinely make referrals to mental health services.

Mrs G has pointed out that St. Andrew's responded on 7 February 2024 saying that it was happy to accept this evidence. However, it's important to note that, at this time, she was still within the three-month period whereby claims for psychological illnesses could be paid without evidence of being under the care of a specialist. So, whilst it was fair for it to accept the self-referral evidence and fit notes as proof that Mrs G was suffering from stress related problems, I'm not persuaded that it was a commitment that the evidence provided would suffice to continue to pay the claim in the longer term or that it didn't still require evidence to confirm the original condition that had required her to have an operation.

Under section 3, for Accident and Sickness Cover, the policy terms state:

'We'll pay you monthly benefit until the earlier of the following:

• *The end date.*

• *The date when your accident or sickness ends, or you fail to provide evidence of your accident or sickness.*

• *The date we've paid you monthly benefit equal to the maximum period of claim.*

By 'evidence' we mean:

• *Doctor's statements and/or medical certificates. You can self-certify for the first 7 days.*

• *Any other evidence we may ask for to prove your claim as detailed in 'Section 6. How to claim.'*

And:

'What this policy doesn't cover.

We won't pay claims if:

• Your claim's not supported by the required information or evidence; or where you're unwilling or unable to provide us with all necessary information or evidence we need in order to validate your claim.'

Under Section 6, about how to claim, the policy goes on to state:

'2. What you'll need to give us

You must help us look after your claim by doing what we ask. We'll ask for supporting evidence to prove your claim. You must provide this at your expense.

• Accident and Sickness Cover:

– If you've had an accident or are sick we'll need to see doctor's statements and/or medical certificates. We'll also need a statement from your employer confirming your absence from work due to an accident or sickness.

– We may ask for and obtain additional medical information from any medical practitioner who's treated you.'

Mrs G has asked where in the policy it states that payment will be withheld if access to medical records is not given. I consider that the above wording clearly sets out that claims won't be paid without adequate medical information.

This is a common term in insurance policies and it's reasonable for an insurer to require evidence of someone's health condition. Whilst understanding Mrs G's desire for privacy, it's unusual for fit notes and consultant's letters to omit a diagnosis and the information provided up to that point did not meet the evidential standards required.

Mrs G has questioned why St. Andrew's paid the claim for the period it did without the evidence that it subsequently said it needed. She makes a good point here as St. Andrew's could reasonably have withheld payment completely until it received more substantive medical evidence. Instead, it started paying the claim whilst continuing to request more information. This has complicated matters as, from Mrs G's point of view, it felt like St. Andrew's had accepted the claim on the evidence provided but then reneged on that agreement. However, overall, it was reasonable for it to start paying the claim on the assumption that the required medical information would be forthcoming. It was seeking assurances about the accuracy of the information previously provided, to gain a fuller picture of the situation. When the information wasn't received, in contravention of the policy terms, it was then reasonable that it ceased payment of the claim.

It was on 29 February 2024 that St. Andrew's told Mrs G it required access to her medical records and sent her an access to medical records form to complete so that it could consider the claim further. It said it wanted to get a better understanding of her condition and prognosis.

Mrs G has said that St. Andrew's own literature states that someone does not have to give their permission for access to medical records. But that is simply making it clear that it doesn't have a legal right to insist that someone consents and that policyholders are within their rights to decline access. It does not suggest that there'll be no impact to the claim or that a claim can continue unhindered without access to such records.

Mrs G complained that she had given St. Andrew's everything that it had asked for and that it had declared itself satisfied. However, that is not the case, as no evidence for the reason for surgery had been provided by this point. Also, the date when stress became the primary

condition was slightly unclear. The first fit note stating ‘stress’ was dated 18 January 2024, but the change could have happened anytime between then and the previous sick note dated 2 January 2024.

St. Andrew’s had consistently asked her to provide more information about her condition from the beginning. If the fit notes and letter from the consultant had been more transparent about a diagnosis, St. Andrew’s may have been satisfied by that evidence, however, it was reasonable for it to conclude that it did not have a full enough picture of the situation. And St. Andrew’s had only said that it was happy with the evidence about self-referral to a talking therapies service, not in relation to the initial claim evidence or the ongoing payments.

On 26 March 2024 St. Andrew’s then did receive Mrs G’s consent to access her medical records. Having told Mrs G that it wouldn’t make any more payments, on the basis of having received her consent, it then did release, on 2 April 2024, the next payment to cover the period 20 February 2024 to 20 March 2024 (having not seen that Mrs G had rescinded her permission in the interim).

Mrs G then said she would be happy for St. Andrew’s to contact her medical practitioners to ask specific questions about her condition but that she was not willing to give access to her medical records. St. Andrew’s agreed to this on 16 May 2024. It sent her a consent form to sign, after which it would contact her GP and consultant. I consider that St. Andrew’s acted reasonably in agreeing this way forward as a compromise.

Mrs G says that St. Andrew’s then changed the reason for not paying the ongoing claim. The policy terms state:

‘*Points to note*

Accident and Sickness cover for psychological illness will be limited to 3 monthly benefit payments unless you've been referred to, and when seen, remain under the care of a specialist.

– By 'psychological illness' we mean; a condition affecting, or arising in, the mind, which is related to your mental and emotional state. This includes all forms of depression, anxiety and stress or stress related illness.

– By 'specialist' we mean; a psychiatrist, psychologist or any mental health nursing team.’

Mrs G says the first time she heard about this reason for discontinuing the claim was from our investigator. However, as set out above, St. Andrew’s initially informed her of this stipulation on 26 January 2024.

Mrs G argues that she has complied with the policy terms because she was indirectly referred to a specialist team by her GP. However, the primary care team that she was referred to does not meet the definition of ‘specialist’ as set out under the policy terms.

She has also queried how it would ever be possible to meet the threshold for a successful claim if it is standard policy for a GP to not make a referral to a specialist but instead ask patients to self-refer to a talking therapy service.

Insurance policies aren’t designed to cover every eventuality or situation. An insurer will decide what risks it’s willing to cover and set these out in the terms and conditions of the policy document. In this case, St. Andrew’s has worded its policy so that it covers only the most severe type of psychological illness over a longer term. However, it will cover less severe conditions for a maximum of three months.

Mrs G says that if St. Andrew's had been clearer about this requirement, she could have spoken to her GP and then met the conditions of the policy. However, I haven't seen any evidence that her GP thought her condition severe enough to warrant a referral to a specialist as defined under the policy. A letter from her GP confirms that she never displayed symptoms which would require referral to a psychiatrist or psychologist. Whilst the GP would undoubtedly have wanted to help, I doubt they would have made such a referral without medical need, to meet the requirements of an insurance claim.

St. Andrew's could have done some things differently. It started to pay the claim, and then continued to pay it, without the necessary medical evidence. It perhaps should have done things by the book and withheld payment until sufficient medical evidence had been received. However, Mrs G has benefitted from St. Andrew's approach as she received the claims payouts without excessive delay that reduced her financial strain at the time.

I have a great deal of sympathy for Mrs G's situation. She underwent an operation and has subsequently suffered from stress and anxiety from a combination of work-related and personal issues. Making a claim, and then a complaint, during such a time can't have been easy. However, the matter at hand is whether St. Andrew's has done anything significantly wrong, and I don't think that it has.

On balance, I find it reasonable that it ceased claim payments on the grounds that Mrs G had not provided all the necessary information to validate the first part of the claim, particularly a diagnosis. It's also reasonable that it won't look at the second part of the claim for stress further until such time that it receives that information, to ensure that the overall claim has been paid correctly.

I'm aware that things have moved on slightly since St. Andrew's sent its final response letters to the complaint on 11 April 2024 and 16 May 2024. Mrs G has subsequently provided a copy of her medical records, although, as she underwent the surgery privately, there was no information about the procedure itself or a confirmed diagnosis. But she has also since said that she doesn't want St. Andrew's to contact her consultant. Therefore, although I understand that St. Andrew's was reviewing the claim, it seems unlikely that it would conclude that it now has sufficient evidence to continue paying the claim. However, should Mrs G provide additional, relevant information, I would expect St. Andrew's to reconsider the claim.

My final decision

For the reasons set out above, I do not uphold the complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs G to accept or reject my decision before 27 May 2025.

Carole Clark
Ombudsman